

study, the role that non-IVDU prostitutes play in perpetuating the AIDS pandemic in Spain seems still to be low.

We believe that data presented here support the hypothesis that the risk of sexual transmission of HCV is low, although additional studies are needed to define more precisely this risk. The study also indicates that, at present in our country, it is the intravenous drug user who puts prostitutes at a significant risk of HCV infection and this also seems to be the case for HIV infection among the same group.

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Transmission of gonorrhoea through an inflatable doll

Nonsexual transmission of gonorrhoea seems to be extremely rare. Only one case of nonsexual transmission of genital *Neisseria gonorrhoeae* is documented in adults¹, involving two patients in a military hospital who shared a urinal. *N. gonorrhoeae* has been shown to survive in infected secretions on towels and handkerchiefs for 20 and 24 hours, respectively.² Cultures from toilet seats in public restrooms and venereal disease clinics have failed to yield *N. gonorrhoeae*.^{3,4}

The skipper from a trawler, who had been 3 months at sea, sought advice for urethral discharge. His symptoms had lasted for two weeks. A urethral smear showed typical intracellular gram-negative diplococci, and a culture was positive for *N. gonorrhoeae*. There had been no woman onboard the trawler; he denied homosexual contacts; and there was no doubt that the onset of the symptoms was more than two months after leaving the port.

With some hesitation, he told the story. A few days before onset of his symptoms, he

had roused the engineer in his cabin during the night because of engine trouble. After the engineer had left his cabin, the skipper found an inflatable doll with artificial vagina in his bed, and he was tempted to have "intercourse" with the doll. His complaints started a few days after this episode.

The engineer was examined, and was found to have gonorrhoea. He had observed a mild urethral discharge since they left port, but he had not been treated with antibiotics. He admitted to having ejaculated into the "vagina" of the doll just before the skipper called him, without washing the doll afterwards. He also admitted intercourse with a girl in another town some days before going to sea. This girl was traced, but the result of her examination is not known. To the best of our knowledge, no case of gonococcal transmission through an inflatable doll has been reported before.

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Analysis of failed appointments in a genitourinary department in the West Midlands of the UK

Failure to keep hospital out-patient appointments is a waste of resources and it may contribute to increased morbidity.¹ Previous studies focused attention on defaulters of initial outpatient appointments.^{2,3} We report on the failure to keep subsequent appointments in a genitourinary department.

Between the period 11 May-10 July 1992, all patients who failed to keep their subsequent appointments were studied and analysed. Whenever they returned to the clinic, they were interviewed with particular attention to their reasons for missing their previous appointments. The interview of those who returned was continued until the end of August 1992. A large proportion of our patients are in the lower socio-economic classes. Statistical analysis was by the Chi square method and Student's *t* test, with $p < 0.05$ taken as significant.

During the period of study, 2973 appointments were scheduled for 76 clinic sessions. There were 745 failed appointments giving a frequency rate of 25.1%. Among the appointments, 1654 were for morning sessions and 1319 for afternoon sessions, of which 454 and 291 respectively were not kept, 27.4% v. 22.1%, $p < 0.001$. There were 1479 male and 1494 female appointments, out of which

342 and 403 respectively were not kept, 23.1% v. 27%, $p < 0.05$. Four hundred and seventy patients (217 males and 253 females) were responsible for these failed appointments. However, 243 (104 males and 139 females) returned to the clinic and were interviewed.

The diagnosis among the 470 defaulters were genital warts 132 (28.1%); *Chlamydia trachomatis* infection 35 (7.4%); Non-specific urethritis 29 (6.2%); genital herpes 10 (2.1%); gonorrhoea 9 (1.9%); *Trichomonas vaginalis* infection 6 (1.3%); positive syphilis serology 2 (0.4%). A large group of "Others" included patients with candidiasis, balanitis, scabies etc. When the incidence of different sexually transmitted diseases among defaulters was compared with that of non-defaulters, the only significant difference was that genital warts were commoner among defaulters 28.1% v. 11.8%, $p < 0.001$. Among those interviewed the reasons for defaulting are shown in the table. There were significant differences between the men and the women. Four women were "afraid" and therefore defaulted. Two of them were pregnant and they thought that further examination would harm their pregnancies. The other two were sick after taking metronidazole tablets and were hence discouraged from making further visits. Out of the 470 defaulters, only two women who had chlamydia cervicitis did not receive appropriate treatment. All efforts by the health advisers to get them back to the clinic were unsuccessful.

The frequency of failed appointments varies between clinical departments; 4.8% reported from a diabetic clinic¹ and 35% in a paediatric clinic.⁴ In our study, since only half of the defaulters came back, their reasons for defaulting cannot be generalised to all defaulters. Nevertheless, some lessons can be learnt from this exercise. The age distribution of defaulters was similar to that of our clinic attenders. Likewise, apart from genital warts, the incidence of many common sexually transmitted diseases was similar among defaulters and non-defaulters. An interpretation of this is that the problem is not peculiar to any age or diagnosis group. There were more defaulters from the morning sessions. This may relate to some of the reasons—work and domestic problems given by the patients. Alteration of clinic times may improve matters.

The importance and the need for a subsequent visit should be stressed by the clinic

staff to the patients. When subsequent appointments are being made, patients should be asked if the date and session are convenient. Secondly, if the patient later on finds out that the appointed time is inconvenient, he/she should be aware that a telephone call to arrange another date is a better alternative to a failed appointment. Identification of remediable causes of failed appointments from indepth analysis and then making appropriate adjustments will lead to efficient use of resources.

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Carcinoma of the vulva and asymptomatic lichen sclerosus

Genitourinary medicine departments are seeing an increasing range of non-infectious problems. We report a patient with asymptomatic lichen sclerosus (LS) who presented with squamous cell carcinoma of the vulva.

A 39 year old female was referred by her general practitioner (GP) with a solitary perineal swelling of one month's duration which had developed three months after a casual sexual contact. Her GP made an initial diagnosis of an infected sebaceous cyst and prescribed antibiotics. She gave no history of sexually transmitted disease (STD), including genital warts and was otherwise asymptomatic.

On examination she was found to have LS of the anterior vulva (confirmed on punch biopsy). She was also noted to have a firm, discreet 1.5 × 1.0 cm raised nodule with a central warty area, lateral and anterior to the anal margin. There was no evidence of condylomata acuminata and no inguinal lymphadenopathy. Biopsy revealed a squamous cell carcinoma. She was referred to the gynaecology department for a wide local excision with block dissection of the inguinal lymph nodes. Histology confirmed complete excision of the tumour, with LS in the surrounding skin, and no evidence of node involvement.

The incidence of vulval carcinoma appears

Table Reasons why patients did not attend

	All patients 243 (%)	Men 104 (%)	Women 139 (%)	p value
Work	48 (19.8)	31 (29.80)	17 (12.20)	0.001
Forgot	56 (23)	26 (25.00)	30 (21.58)	NS
Holiday/travel	22 (9.1)	11 (10.58)	11 (7.91)	NS
Clerical error	24 (9.9)	10 (9.62)	14 (10.10)	NS
Felt well	17 (6.7)	9 (8.65)	8 (5.76)	NS
Domestic problems	29 (11.9)	7 (6.73)	22 (15.83)	0.025
Illness	27 (11.1)	6 (5.77)	21 (15.10)	0.025
Not asked	6 (2.5)	3 (2.88)	3 (2.16)	NS
School	10 (4.1)	1 (0.96)	9 (6.47)	0.025
Afraid	4 (1.7)	0	4 (2.88)	